PRINTED: 06/21/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		15G442	A. BUILDING B. WING		05/24/2012	
				ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R		VING LN		
RES CAI	RE COMMUNITY A	LTERNATIVES SE IN		RSONVILLE, IN 47130		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX		NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	RIATE	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
W0000						
			11/0000			
		post certification revisit	W0000			
	(PCR) to the inv	restigation of complaint				
	#IN00104904 co	ompleted on March 16,				
	2012.					
	Complaint #IN0	0104904: Corrected.				
	P					
	Unrelated defici	ancies cited				
	Officialed defici	cheres effed.				
	D t CC	M 22 22 124				
	1	: May 22, 23, and 24,				
	2012.					
	Facility Number	r: 000956				
	Provider Numbe	er: 15G442				
	AIMS Number:	100244760				
	Surveyor: Dotty	y Walton, Medical				
	Surveyor III.	,				
	Sui 10 y Oi 111.					
	The following d	eficiencies reflect state				
	_					
	_	rdance with 460 IAC 9.				
		completed 6/4/12 by Ruth				
	Shackelford, Me	edical Surveyor III.				
			1			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIIII	A. BUILDING 00 COMP			ETED
		15G442	B. WIN			05/24/	2012
		1	Γ		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	8			/ING LN		
		LTERNATIVES SE IN		JEFFEF	RSONVILLE, IN 47130		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0120	SOURCES	OVIDED WITH OUTSIDE assure that outside services of each client.					
	Based on observ	ation, record review and	W0	120	Corrective Action: (Specific))	06/23/2012
		of 3 sampled clients (B),			The Program Coordinator wil		
	· ·	to ensure the day			train the workshop staff on Cli		
	1	rs were apprised of			B's diet plan. Client B will be monitored by the PC/designed	NC	
	*	B's programming and			during the meal at the workshop		
		egarding an episode of			and the home to ensure the	r	
	choking.	guranig an episode of			dining plan is being followed.		
	Choking.				Program Coordinator will infor		
	Findings include	:	the workshop staff of any chokir incident that occurs on all clients		•		
	day program on until 12:30 PM. staff and ate can of fresh fruit. Review of invest on 5/22/12 at 3:1 episode of choki 5/11/12. The incident rep client A was atte at 5:00 PM and of cauliflower. The	served eating lunch at her 5/23/12 at 11:50 AM She was monitored by ned fruit cocktail instead tigations/incident reports 15 PM indicated an ng with client A on ort review indicated ending a dance on 5/11/12 choked on a piece of report by facility staff #4			How others will be identified (Systemic) Before being admitted to the workshop, all Program Coordinators train th workshop staff on all client din plans. The Program Coordinators inservice all revisions of dining with worksh staff. Measures to be put in place: The Program Coordinator will train the workshop staff on Cli B's diet plan. Client B will be monitored by the PC/designed during the meal at the workshop and the home to ensure the dining plan is being followed. Program Coordinator will info	e nop ll ent es op The rm	
	she choked on the cauliflower," sta	B was eating and when he "small piece of ff #4 did the Heimlich her to bring it up."			the workshop staff of any cholincident that occurs on all clief Monitoring of Corrective Action: The Operations Manager or the Director of Supervised Group Living will	-	

PRINTED: 06/21/2012 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G442	(X2) MU A. BUII B. WIN	LDING	onstruction 00	(X3) DATE : COMPL 05/24/	ETED
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN		402 EW	ADDRESS, CITY, STATE, ZIP CODE VING LN RSONVILLE, IN 47130		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE
IAU	investigation/inc 5/23/12 at 3:30 F an investigation client B had chol her day program lunch. The investigation of the day program skill 10:30 AM stated [skills trainer #9] choking. She inition the orange slice of Skills trainer #10 eating and did not and the Heimlich trainer #9]. The whole still." The Coordinator/Quan Disabilities Profession was interviewed PC #1 stated: "[Cointo small pieces plan. However, [Corange so it had appropriately." The summary conclusion orange in her with her modified client's lunch was appropriate consums to be cut into was to be promp thoroughly.	ident reports was done on PM. The review indicated of a incident wherein ked on an orange slice at on 12/02/11 during stigation's interview with ls trainers on 12/02/11 at client B "came up to her pointing at her throat, that the Heimlich and was removed whole." O stated "[Client B] was not chew her orange well in was initiated by [skills brange came up looking the client's PC/Program lified Developmental essional-designee staff #1 on 12/2/11 at 1:00 PM. Client B's] food was cut as required in the diet client B] had snuck the mot been properly cut up		IAU	ensure that all diet plans are reviewed by workshop staff. The Operations Manager or to Director of Supervised Group Living will ensure that the workshop is notified of any cochoking episode.		DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: VMXE12

Facility ID: 000956

If continuation sheet

Page 3 of 14

PRINTED: 06/21/2012 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G442	A. BUI	LDING	NSTRUCTION 00	(X3) DATE COMPL 05/24/	ETED
		.55	B. WIN		DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	t		402 EW			
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN			SONVILLE, IN 47130		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFECT.)		DATE
		7/23/12 at 12:05 PM. The					
	Manager indicate						
		eine sodas belonging to					
	_	rom the staff refrigerator					
		nem. Skills trainers #9					
		rerviewed on 5/23/12 at					
		vorkshop staff were					
		ad an episode of choking					
		ver on 5/11/12. The					
	workshop's copy of client B's dining plan						
(reviewed 5/23/12 12:05 PM) was dated 12/02/11. Review of client B's record on							
		PM indicated a dining					
	_	12 which listed the most					
		pisode. The record					
		LPN #10 had made more					
		cy recommendations on					
		nw vegetables." The day					
		have this information. w indicated a 5/18/12					
		ort Plan/ISP meeting					
		at the workshop. PC #1					
		new dining plan or					
		rding the 5/11/12 with client B at the ISP					
	-						
	meeting with wo	rkshop starr.					
	Interview with C	Oualified Developmental					
	· `	essional staff #2 on					
		PM indicated the day					
	_	rs should have been					
	with client B.	atest choking incident					
	with Chefft B.						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: VMXE12

Facility ID: 000956

If continuation sheet

Page 4 of 14

PRINTED: 06/21/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER: 15G442	A. BUILDING B. WING		COMPLETED 05/24/2012		
	PROVIDER OR SUPPLIER RE COMMUNITY ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP CODE 402 EWING LN JEFFERSONVILLE, IN 47130				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX CRC TAG	PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BE DSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE		
	This deficiency was cited on 3/16/12. The facility failed to implement a systemic plan of correction to prevent recurrence.					
	9-3-1(a)					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: VMXE12

Facility ID: 000956

If continuation sheet Page 5 of 14

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MUL	TIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	00	COMPLETED	
		15G442	B. WING			05/24/	2012
NAME OF I	DROWNER OF CURRINE		· [STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER] .	402 EW	ING LN		
		TERNATIVES SE IN			RSONVILLE, IN 47130		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE		DATE
W0154	483.420(d)(3)	IENT OF CLIENTS					
		have evidence that all					
		s are thoroughly investigated.					
	i -	review and interview, for	W015	54	Corrective Action: (Specific)		06/23/2012
	1 of 3 sampled cl	lients (B), the facility			The Quality Assurance staff w	ill	
	_	in episode of choking			be retrained that all alleged violations (which includes		
		gated to ascertain the			choking) will be thoroughly		
	'	facilitate corrective			investigated. Recommended		
	measures.				corrective measures to preven		
	111000001001				violations, such as choking, wi		
	Findings include				be included in the investigation		
	Tillulings illerude	•			The Quality Assurance staff w thoroughly investigate Client E		
	Davious of invest	igations/incident reports			choking on a small piece of	'	
		igations/incident reports			cauliflower. Recommended		
		5 PM indicated an			corrective measures will be		
	_	ng with client A on			included in the investigation.		
	5/11/12.				How others will be identified		
	-	ort review indicated			(Systemic) When investigation are concluded by the Quality	าร	
	client A was atte	nding a dance on 5/11/12			Assurance Team,		
	at 5:00 PM and c	hoked on a piece of			recommendations for preventing	ve	
	cauliflower. The	report by facility staff #4			measures will be stated.		
	indicated client E	B was eating and when			Measures to be put in place:		
	she choked on th	e "small piece of			The Quality Assurance staff w	ill	
		ff #4 did the Heimlich			be retrained that all alleged violations (which includes		
	Maneuver "on he				choking) will be thoroughly		
		. O P			investigated. Recommended		
	A second review	of facility			corrective measures to preven		
		ident reports was done on			violations, such as choking, wi		
	_	M. The review indicated			be included in the investigation		
					The Quality Assurance staff w thoroughly investigate Client E		
	_	of a incident wherein			choking on a small piece of	'	
		ked on an orange slice at			cauliflower. Recommended		
		on 12/02/11 during			corrective measures will be		
	-	t B] had snuck the orange			included in the investigation.		
	so it had not been	n properly cut up			Monitoring of Corrective		
					Action: The Executive Director	r	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: VMXE12

Facility ID: 000956

If continuation sheet Page 6 of 14

PRINTED: 06/21/2012 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G442	(X2) MU A. BUIL B. WING	DING	NSTRUCTION 00	(X3) DATE : COMPL 05/24 /	ETED
NAME OF F	PROVIDER OR SUPPLIER		İ		ADDRESS, CITY, STATE, ZIP CODE	•	
RES CAF	RE COMMUNITY AI	TERNATIVES SE IN		402 EW JEFFEF	RSONVILLE, IN 47130		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
TAG	appropriately." Tsummary concludes an orange in her with her modified client's lunch was appropriate constructions was to be cut into was to be promper thoroughly. The 5/23/12 3:30 investigations into of the 5/11/12 characteristic client B. The 5/1 administrator on summary of evid B] was at workshevent and when so cauliflower she do the food and she immediately perfection [client B] spit out staff were follow procedure during investigative "cook is the conclusion committee that [client B] the conclusion committee that [client B] workshop." There was no me of choking, her having with her diet order with her diet order.	the investigative ded client B had placed lunch container along d consistency meal. The sto be checked for istency foods, her food is small pieces and she ted to chew her food. PM review of dicated the investigation oking incident with 1/12 (reviewed by the 5/18/12) investigation ence indicated "[Client nop for an after hours she took a bite of lidn't completely chew up got choked. Staff formed the Heimlich and to the cauliflower. All ing [agency] policy and the incident." The inclusion and findings: It of the investigation client B] choked on a wer while she was at the incident of client B's history istory of taking food sistent (whole orange) er, her need to wear her atting, and her need to be		TAG	will review all investigations to ensure preventive measures a included in all completed investigations.)	DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: VMXE12

Facility ID: 000956

If continuation sheet

Page 7 of 14

PRINTED: 06/21/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED		
ANDILAN	15G442	A. BUILDING	00	05/24/2012		
	100772	B. WING	DDDDGG GYMY GM :	0012712012		
NAME OF F	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE			
RES CAF	RE COMMUNITY ALTERNATIVES SE IN	402 EWING LN JEFFERSONVILLE, IN 47130				
	SUMMARY STATEMENT OF DEFICIENCIES	ID		(V5)		
(X4) ID PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE		
	meals/snacks. There was no information					
	in the investigation which indicated how					
	big the piece of cauliflower was, if the					
	client had taken the food with/without					
	permission or staff supervision. The					
	investigation did not indicate if the client					
	was wearing her dentures (she was					
	edentulous and had full dentures), how					
	much supervision she had or if she was					
	being prompted to chew slowly and cut					
	up her cauliflower into small pieces					
	during the episode. There were no					
	recommendations listed in the					
	investigation to implement as corrective					
	measures for the choking with client B.					
	Interview with Quality Assurance Staff #1					
	on 5/23/12 at 3:30 PM indicated the					
	investigation started 5/11/12, was					
	reviewed by the administrator on 5/18/12,					
	and this was the extent of the					
	investigation at the time of the survey.					
	This deficiency was cited on 3/16/12.					
	The facility failed to implement a					
	systemic plan of correction to prevent					
	recurrence.					
	9-3-2(a)					
	l .	1		I		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: VMXE12

Facility ID: 000956

If continuation sheet

Page 8 of 14

PRINTED: 06/21/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 15G442	A. BUILDING B. WING	00		LETED L/2012		
	PROVIDER OR SUPPLIE	R ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP CODE 402 EWING LN JEFFERSONVILLE, IN 47130					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: VMXE12

Facility ID: 000956

If continuation sheet

Page 9 of 14

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			TED	
		15G442	B. WIN			05/24/2	.012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			l	/ING LN		
RES CAF	RE COMMUNITY AI	LTERNATIVES SE IN			RSONVILLE, IN 47130		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	R'S PLAN OF CORRECTION	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0159	PROFESSIONA Each client's acti be integrated, co	NTAL RETARDATION L ive treatment program must pordinated and monitored by al retardation professional.					
	Based on observa	ation, record review and	W0	159	Corrective Action: (Specific)		06/23/2012
		of 3 sampled clients (B),			The Program Coordinator will		
		fied Developmental			retrain the Program Coordinate	or	
	-	essional/QDDP failed to			that workshop staff are to be inserviced on all client dining		
		nate, and monitor client			plans and revisions. The		
	"	ent program in regards to			Program Coordinator and the		
	a choking episod	1 0			QMRP will be retrained that		
	a choking episod	c.			immediate preventive measure		
	Findings include	:			are put in place to prevent furtl choking episodes. The Nurse and the QMRP will retrain all the		
	Please refer to W	120 for the QDDP's			staff on all client dining plans,		
		nate with the day services			including client B. How others will be identified:		
		ify them of client B's			(Systemic) Before being	•	
	_	on 5/11/12 and give			admitted to the workshop, all		
		cent dining plans.			Program Coordinators train the	е	
	them the most re	cent diffing plans.			workshop staff on all client din	ing	
	Dlagga rafar to W	1154 for the ODDD's			plans. The Nurses and the		
		7154 for the QDDP's client B's 5/11/12			Program Coordinators train all staff on dining plans of all clier		
					before admission to the home.		
		was fully investigated to			The Nurses and the Program		
		ial events and corrective			Coordinators train staff on any	,	
		nplemented immediately			dining plan revision on the clie	nts.	
	to protect client l	B while assessments were					
	being conducted.				Massumes to be must be misses.		
					Measures to be put in place: The Program Coordinator will		
	Please refer to W	189 for the failure of the			retrain the Program Coordinate	or	
	QDDP to monito	or the facility staff for			that workshop staff are to be		
	-	g client B's dietary			inserviced on all client dining		
		o choking and how to			plans and revisions. The		
	~	y guidelines regarding			Program Coordinator and the		
	I mpiomont dictar	J Baracinios regulating			QMRP will be retrained that		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: VMXE12

Facility ID: 000956

If continuation sheet

Page 10 of 14

PRINTED: 06/21/2012 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G442	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/24/2012
	PROVIDER OR SUPPLIER RE COMMUNITY ALTERNATIVES SE IN	402 EV	ADDRESS, CITY, STATE, ZIP CODE VING LN RSONVILLE, IN 47130	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
	cutting sandwiches into small pieces as needed. 9-3-3(a)		immediate preventive measurare put in place to prevent fur choking episodes. The Nurse and the QMRP will retrain all staff on all client dining plans including client B. Monitoring of Corrective Action: The Program Coordinator, the QMRP, or the Nurse will monitor the staff to ensure that staff follow all din plans for all the clients.	ther ether the

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: VMXE12

Facility ID: 000956

If continuation sheet

Page 11 of 14

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	URVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETI			ETED	
		15G442	B. WIN			05/24/2	2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIE	R			VING LN		
RES CAF	RE COMMUNITY A	ALTERNATIVES SE IN			RSONVILLE, IN 47130		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0189	initial and contir employee to pe effectively, effic	t provide each employee with nuing training that enables the erform his or her duties iently, and competently.	W0	190	Corrective Actions (Specific		06/23/2012
		vation, record review and	W 0	109	Corrective Action: (Specific) The Nurse and the Program	'	00/23/2012
	· ·	of 3 sampled clients (B),			Coordinator will retrain all the		
	_	d to ensure the direct			staff on all client dining plans,		
		d been adequately trained			including client B, and all		
		t B's meal in a small			revisions of client diet plans,		
	pieces after an e	episode of choking.			including client B.	.	
	Findings include	e:			How others will be identified: (Systemic) The Nurses and the Program Coordinators train all staff on		
	During observat	tions at the facility on the			dining plans of all clients before	re	
	evening of 5/22	/12 from 5:15 PM until			admission to the home. The		
	7:00 PM, the ev	ening meal was observed.			nurses and Program Coordinators train staff on any	,	
	· ·	n the table and the clients			dining plan revisions on the		
	were eating as s	taff #3 was cutting up			clients.		
	_	The food consisted of a			Measures to be put in place:		
	 baked hamburge	er pattie on a bun, potato			The Nurse and the Program Coordinator will retrain all the		
	1	natoes, sliced pickles, and			staff on all client dining plans,		
	_	1. Staff #3 stated the			including client B, and all		
		s cut into 16 pieces." The			revisions of client diet plans,		
		to be large (1 inch by			including client B.	_	
		thick) so LPN #10 was			Monitoring of Corrective Act The Program Coordinator, the		
		e surveyor. LPN #10			QMRP, or the Nurse will monit		
		cut each piece of the			the staff to ensure that staff		
		n into smaller pieces.			follow all dining plans for all th	e	
		d her meal and placed her			clients.		
	dentures into he	_					
	dentures into he	т роскет.					
		stigations/incident reports 15 PM indicated an					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: VMXE12

Facility ID: 000956

If continuation sheet Page 12 of 14

PRINTED: 06/21/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDE		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G442	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/24/2012			
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP CODE 402 EWING LN JEFFERSONVILLE, IN 47130					
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION	
	episode of choking 5/11/12. The incident reported in the incident reported in the indicated client in the indicated in	cy MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION) Ing with client B on ort review indicated adding a dance on 5/11/12 shoked on a piece of report by facility staff #4 B was eating and when the "small piece of ff #4 did the Heimlich for to bring it up." of facility ident reports was done on ff. The review indicated for a incident wherein fixed on an orange slice at for 12/02/11 during fixed Developmental fixed De			(EACH CORRECTIVE ACTION SHOULD BI			
		n client B's doctor on						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: VMXE12

Facility ID: 000956

If continuation sheet

Page 13 of 14

PRINTED: 06/21/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER: 15G442	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 05/24/2012			
	PROVIDER OR SUPPLIER RE COMMUNITY ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP CODE 402 EWING LN JEFFERSONVILLE, IN 47130					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)	OBE COMPLETION			
	5/15/12. The doctor indicated "progressive dysphagia for solids, choked on cauliflower earlier this week. Has been choking intermittently, endures heartburn daily." The doctor recommended the following: "Diet restrictions: canned fruit (no fresh fruit) sandwiches and meat into 16 pieces. Eat slowly" The record review indicated LPN #10 had made more dietary consistency recommendations on 5/18/12 of "no raw vegetables." Interview with LPN #10 and PC #1 on 5/22/12 at 6:25 PM indicated client B's hamburger required extra cutting and she should not have raw vegetables (pickles, onions) or raw fruit (tomatoes) until she had further assessments of her chewing/swallowing capabilities. 9-3-3(a)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: VMXE12

Facility ID: 000956

If continuation sheet

Page 14 of 14